PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

pienkowskimd.com

6-12 MONTH CHECKUP QUESTIONNAIRE FORM

Part 1 of 2

Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____

Age: _____ Weight: _____ Height: _____

Primary Care Physician: _____

Pharmacy Name: _____

Address: _____

City, State, Zip: _____

Medical History Update

What percentage of improvement you have had with your allergies/asthma?

○ 0% ○ 10% ○ 20% ○ 50% ○ 70% ○ 90%

Do you have any reactions with your immunotherapy (allergy injections)?

○ Yes ○ No ○ Not Applicable

Are you taking all allergy and/or asthma medications as prescribed?

○ **No** (Why not?): _____

○ **Yes** (List name, dosage, frequency, etc.):

List all DRUG ALLERGIES: _____

Are you currently, or have you ever been treated for substance abuse? If so, explain: _____

Do you, or does anyone in your home smoke? ○ **Yes** (How much?): _____

Do you have any pets inside your home? ○ **Yes** (What Type?): _____

Do you have any exposure to mold (Household, Dust, Hay?) ○ **Yes** (Explain): _____

Surgery/Medical Treatment Update

List any surgeries/medical treatments in the past year: _____

List all medical conditions
Other than Allergies/Asthma. For which you are being treated and the medications used to treat those conditions:

List any other concerns regarding your allergies or asthma that you would like to review: _____

Complete Next Page

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Part 2 of 2

Name: _____

Asthma Update (Skip if not applicable)

In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

During the past 4 weeks, how often have you had shortness of breath?

○ Once a day ○ 3- 6 times a day ○ Once or twice a week ○ Not at all

During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

○ 4 or more nights a week ○ 2 or 3 nights a week ○ Once a week ○ Once or twice ○ None of the time

During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medications (such as Albuterol)?

○ 3 or more times a day ○ 1 or 2 times a day ○ 2 or 3 times a week ○ Once a week or less ○ Not at all

How would you rate your asthma control during the past 4 weeks?

○ Not controlled at all ○ Poorly controlled ○ Somewhat controlled ○ Well controlled ○ Completely controlled

Allergy Update (Skip if not applicable)

Do you have any of the following symptoms?

○ Sniffles, sneezing; itchy or runny nose?	○ Spring	○ Summer	○ Fall	○ Winter
○ Sneezing, which is frequent and possibly painful?	○ Spring	○ Summer	○ Fall	○ Winter
○ Postnasal drip (down the back of your throat)?	○ Spring	○ Summer	○ Fall	○ Winter
○ Loss of smell?	○ Spring	○ Summer	○ Fall	○ Winter
○ Thick, green or yellow drainage from your nose?	○ Spring	○ Summer	○ Fall	○ Winter
○ Nosebleeds (1 or more times per year)?	○ Spring	○ Summer	○ Fall	○ Winter
○ Loss of taste?	○ Spring	○ Summer	○ Fall	○ Winter
○ Red, itchy, watery eyes?	○ Spring	○ Summer	○ Fall	○ Winter
○ Dark circles under eyes?	○ Spring	○ Summer	○ Fall	○ Winter
○ Puffy eyes?	○ Spring	○ Summer	○ Fall	○ Winter
○ Headaches?	○ Spring	○ Summer	○ Fall	○ Winter
○ Pain or pressure on any parts of your face?	○ Spring	○ Summer	○ Fall	○ Winter
○ Fatigue (tiredness)?	○ Spring	○ Summer	○ Fall	○ Winter
○ Earaches?	○ Spring	○ Summer	○ Fall	○ Winter
○ Past sinus infections?	○ Spring	○ Summer	○ Fall	○ Winter

Rate your seasonal allergies? (Check all that apply)

Spring:	○ Mild	○ Average	○ Severe
Summer:	○ Mild	○ Average	○ Severe
Fall:	○ Mild	○ Average	○ Severe
Winter:	○ Mild	○ Average	○ Severe

Do your allergies get worse after any of the following activities? (Check all that apply)

○ Spending time outdoors ○ After cleaning house

○ When around animals ○ Other (Explain below):

_____

_____

Patient Signature: _____ **Date** _____

Provider Signature _____ **Date** _____